STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 24, 2023

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #:	AL250381018
Investigation #:	2023A0123066
	Living Joy AL

Dear Connie Clauson:

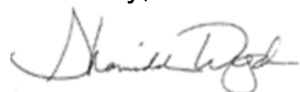
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL250381018
Investigation #:	2023A0123066
Complaint Receipt Date:	08/30/2023
Investigation Initiation Date:	09/01/2023
Report Due Date:	10/29/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Stacy Bohn
Licensee Designee:	Connie Clauson
Name of Facility:	Living Joy AL
Facility Address:	1525 Pierson Road Flushing, MI 48433
Facility Telephone #:	(810) 659-8507
Original Issuance Date:	05/19/2016
License Status:	REGULAR
Effective Date:	11/19/2022
Expiration Date:	11/18/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• It is unknown if the staff are showering Resident A at least once weekly. The staff leave the same clothes on Resident A for days at a time. • Resident A is left for long periods in heavily soiled briefs. Resident A's briefs have urine and feces in it and are heavy. Resident A has been observed with a black substance in his briefs possibly from the brief rubbing on Resident A's skin.	Yes Yes
Additional Findings	Yes

III. METHODOLOGY

08/30/2023	Special Investigation Intake 2023A0123066
08/31/2023	APS Referral Received APS referral.
09/01/2023	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
09/05/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
09/22/2023	Contact - Telephone call made I spoke with Resident A's PACE social worker, Debbie Truxton, via phone.
09/22/2023	Contact - Telephone call made I interviewed staff Keyosha Hall via phone.
10/04/2023	Contact- Telephone call made I made a call to the facility. I interviewed staff Sabra Thomas.
10/04/2023	Contact- Telephone call made I spoke with Guardian 1.
10/18/2023	Contact- Telephone call made I left a voicemail requesting a return call from staff Sabra Thomas.

10/18/2023	Contact- Telephone call made I made a follow-up call to PACE. I spoke with Kayla Tolspyka.
10/18/2023	Contact- Telephone call received I conducted a follow-up call with staff Sabra Thomas.
10/18/2023	Contact- Telephone call made I left a voicemail requesting a return call from staff Randy Peters.
10/19/2023	Contact- Telephone call made I left a voicemail for staff Keyosha Hall, requesting a return call.
10/20/2023	Contact- Telephone call received I interviewed staff Randy Peters via phone.
10/23/2023	Contact- Telephone call received I conducted a follow-up interview with staff Keyosha Hall.
10/19/2023	Contact- Telephone call made I left a voicemail for licensee designee Connie Clauson, requesting a return call regarding the exit conference.
10/23/2023	Contact- Telephone call made I attempted to contact Connie Clauson. There was no answer.
10/23/2023	Contact- Document Sent I sent an email to Connie Clauson, requesting a return call regarding the exit conference.
10/24/2023	Exit Conference I sent an email to licensee designee Connie Clauson.

ALLEGATION:

- **Resident A is supposed to get a shower once weekly. It is unknown if the staff are showering Resident A. The staff leave the same clothes on Resident A for days at a time.**

- **Resident A is left for long periods in heavily soiled briefs. Resident A's briefs have urine and feces in it and are heavy. Resident A has been observed with a black substance in his briefs possibly from the brief rubbing on Resident A's skin.**

INVESTIGATION: On 09/01/2023, I spoke with Complainant 1 via phone. Complainant 1 stated the following:

Resident A has resided in the facility since May 2022. Resident A can ambulate without assistance and uses a walker sometimes. At times, Resident A can be unstable, and is supposed to use his walker. Resident A has dementia and cognitive limitations but is not on hospice. Resident A needs assistance with showering because he will not clean

himself well. Resident A needs assistance with putting on his pants and shirts. Resident A is enrolled in the PACE program (*Program of All-Inclusive Care for the Elderly*) and has a case manager through PACE. Since December 2022, Guardian 1 has had to provide care quite a few times to Resident A, including showering Resident A. The home manager is Stacy Bohn.

On 09/01/2023, Complainant 1 sent photos of what Complainant 1 stated were Resident A's dirty briefs. The brief appeared to have a brown substance in it. The briefs appeared dirty.

On 09/05/2023, I conducted an unannounced on-site visit at the facility. I interviewed administrator Stacy Bohn. Staff Bohn stated that Resident A does wear briefs, but Resident A can go to the bathroom on his own. Resident A just does not change his briefs when soiled. Staff are stand by assist for showers to make sure he is washing himself good. There is a shower schedule, and Resident A is showered three times per week during the early mornings on third shift. Resident A does refuse showers, but she has not heard of him refusing any showers recently. Resident A can change his clothing, and he is changed often throughout the day. Laundry is washed frequently. Resident A is on a pureed diet, and he dribbles (his food). She stated that one time in the past, Resident A's clothing was laundered, and then third shift dressed Resident A in the same (clean) outfit, and Guardian 1 complained about it. A lot of Resident A's clothing looks the same, but the clothing is not dirty. There have been conferences with the family about issues. A few months ago, Guardian 1 was upset that Resident A had a wet brief on, but Resident A had been at the PACE program all day since 8:00 am and had not been in the facility's care prior to a 2:00 pm appointment Resident A had. Staff Bohn stated that things were sorted out with PACE, and now the program staff helps Resident A with his toileting. Staff do brief checks and changes frequently with Resident A.

On 09/05/2023, I obtained requested documentation during the on-site visit. A copy of Resident A's *Assessment Plan for AFC Residents* dated 03/16/2023 notes that for toileting, Resident A "*wears briefs staff x1 will assist in the bathroom to ensure changing brief and clean*." In regard to bathing the assessment plan states "*Staff x1 will assist for safety and to ensure changing clothes and cleaning through.*" Under dressing it states, "*Staff x1 to assist to ensure he changes all clothing into clean clothes daily.*" For hygiene it states "*Staff x1 to assist to ensure hygiene is being completed.*"

On 09/05/2023, I interviewed Resident A at the facility in his bedroom. It was difficult to understand Resident A clearly. Resident A did report that he likes living in the facility but wants to move back home. Resident A has lived in the home for about two years. He stated that some staff "*give him trouble*" because they "*act up*." He stated that he cusses at the staff when they upset him. When asked what staff does to upset him, he stated "*some of everything*." Resident A stated that staff sometimes puts him in clean clothing, and daily he changes once, sometimes more than once. He stated that he has clean clothing, staff does his laundry and brings his clean clothing back to his room. Staff helps with briefs sometimes. He stated that sometimes his pants are wet when

staff checks him, sometimes staff assist him in the bathroom, and sometimes he goes on his own. When asked if staff are meeting his needs, Resident A replied “yeah.” When asked if staff cleans his room, he stated that he sometimes does it himself. Resident A stated that he showers daily, once a day, sometimes twice. He stated that he put a brief on this morning, and it is clean, and that he showered today.

Resident A and about 12 other residents were observed during this on-site. They all appeared clean and appropriately dressed.

On 09/22/2023, I spoke with Resident A’s PACE social worker Debbie Truxton via phone. Debbie Truxton reported that she cannot say concretely that there are any issues with personal care at the facility. She sees Resident A at the PACE day center. Resident A has dementia. There have been concerns raised about Resident A’s care at the facility as well as PACE. Resident A can independently walk with a walker and would use the bathroom independently. When a concern about him having soiled briefs came up, although it is not PACE’s policy, they have agreed to assist Resident A with toileting before leaving to go back to his facility. She stated that they try to work as a team. She also stated that she is not the best person to answer questions on hygiene, but she has seen Resident A with clothing that has had food either on his shirt or pants but cannot say it is a regular occurrence.

On 09/22/2023, I interviewed staff Keyosha Hall via phone. Staff Hall stated that Resident A is supposed to shower three times per week on either second or third shifts. Sometimes Resident A’s clothing presents as clean, and sometimes not. Resident A may have few stains, or may be wearing the same clothing he had on before. Resident A will sometimes wear the same outfit for more than one day at a time, and either he will redress in the same clothing, or staff will redress him in the same clothing. Staff Hall also noted that laundry is done all day, every day and that Resident A keeps a basket of laundry in his bedroom. Staff Hall stated that Resident A has only had a soiled brief once or twice after returning to the facility after spending the day at the PACE program. Staff Hall denied that Resident A has any skin breakdown.

On 10/04/2023, I made a call to the facility. I interviewed staff Sabra Thomas. Staff Thomas stated that Resident A’s hygiene varied depending on which staff were working. Resident A has returned back to the facility from PACE soiled, and staff have documented that. Third shift are responsible for doing two-hour brief checks as well as getting the residents up in the morning and getting them to the table for breakfast. The residents are at the breakfast table when first shift staff start their shifts. Resident A sometimes had wet pants after breakfast. Resident A would have soiled briefs and clothing at breakfast time and would have to be cleaned up afterwards. Staff Thomas stated that Resident A has had soiled clothing and briefs about ten times, at least once per week, and that personal care had to be provided to him in the morning after breakfast. Staff Thomas stated that since Resident A’s choking incident on 08/31/2023, staff have stepped up to make sure Resident A’s hygiene is good. Staff Thomas stated that she does not know how often Resident A is supposed to shower. Resident A was

scheduled for showers on third shift, but she does not think he received showers. She stated that the problem staff on third shift no longer work in the facility anymore. Two staff quit. Staff Thomas then stated that the shower schedule indicates that Resident A was on the schedule for Tuesday, Thursday, and Saturday third shift. Some staff do not document that the showers were completed. She stated that the shower tracking sheet is the emptiest sheet they have. In regard to Resident A's clothing, sometimes Resident A would be wearing the same clothing, and would sleep in his clothing overnight. The facility does wash clothing, and sometimes he would put the same clothes back on because his outfits were not being alternated. Some days you could tell when Resident A's clothing had not been washed. Staff Thomas stated that she has seen a black substance in Resident A's brief that was not feces. She stated that Resident A had dry skin and it looked like his skin was rubbing off into the brief, and that the same would happen when you take a washcloth to wash Resident A's face. The towel would be brown with skin particles on the towel. She stated that she has no idea what it is, it's always been an issue, and she cannot say it was dirt.

10/04/2023, I spoke with Guardian 1 via phone. Guardian 1 stated that Resident A moved to a different facility last Friday. Prior to the move, it was evident that staff were trying to improve but the damage was done since there were ongoing issues since December 2022 regarding Resident A's personal care. Guardian 1 stated that it was dirt on Resident A's skin, not his skin rubbing off. Resident A would be in soiled clothing during the afternoon on first and second shifts. Resident A would be unclean. His showers used to be on third shift but was changed to second shift. Guardian 1 would have to shower Resident A personally, and it got to the point where Guardian 1 felt "*I don't even work here. I'm doing ya'll job*."

On 10/18/2023, I made a follow-up call to PACE. I spoke with Kayla Tolspyka, activity director. She stated that she only saw Resident A about once per week. There were no concerns brought to her attention from her staff or CNA's. Resident A did have difficulty with plate to mouth movement at mealtime, but she never noticed him being unkempt or having any odors while at program.

On 10/20/2023, I interviewed staff Randy Peters via phone. Staff Peters works third shift at the facility. Staff Peters stated that Resident A did his toileting independently in the middle of the night and would do so maybe two to three times per night. Resident A did not care for staff assisting him with dressing and would wear several layers of clothing. In the last eight to twelve weeks of his stay at the facility, Resident A would allow Staff Peters to assist him with dressing. Staff Peters denied knowing which shift Resident A would receive his showers, and that the showers probably happened on days Staff Peters was not present working. When asked if he knew whether or not Resident A was cleaning himself well, Staff Peters stated that Resident A did not appear "gross" and did not have any skin irritation or open sores. Staff Peters stated that Resident A's frontal area was "*in line with a man that toilets himself*" and that Staff Peters did not see any "smegma." When asked if he ever saw any brown stuff in Resident A's briefs, Staff Peters stated "always", and that the brown stuff in Resident A's briefs were his

"*melanin/skin color*" that would rub off. He stated that it is the "*brown tinting*" on Black people, and that he has seen this before in others.

On 10/23/2023, I conducted a follow-up interview with staff Keyosha Hall. She stated that she did witness Guardian 1 providing personal care to Resident A. She stated that Guardian 1 would come in to shave Resident A, wipe him up, and sit clothing out for him. She stated that she cannot say whether or not Guardian 1 provided showers to Resident A because she did not witness it. I inquired about Resident A's "*melanin*." She stated that she had started to pay attention to his briefs after it was mentioned. She stated that Resident A would be dry, but his brief would be brown, as well as wipes when she would wipe Resident A. This would be the case even if Resident A did not urinate or have a bowel movement. She stated that it could have been from staff not bathing Resident A like they were supposed to. She stated that it was possibly dirt. Staff Hall stated that staff did let Resident A toilet himself and not provide assistance. Staff were looking at the situation as Resident A was doing it himself and did not need assistance. Resident A probably was not cleaning and wiping himself well. Staff Hall stated that she was a medication passer and did not often provide personal care to Resident A. Resident A was supposed to get three showers per week on second shift. Staff were not documenting that they were doing showers, and Resident A would wear the same clothing for days at a time.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Complainant 1 reported that Resident A needs assistance with showering due to him not cleaning himself well. Complainant 1 stated that Guardian 1 has had to provide care quite a few times to Resident A, including showering since December 2022. Complainant 1 provided photos of what appears to be dirty briefs worn by Resident A. Administrator Stacy Bohn stated that Resident A had a history of refusing showers, but that Resident A is a standby assist for showers, and staff did checks and brief changes frequently for Resident A. Staff Bohn stated that Resident A dribbles food on his clothing, but his clothing is laundered. Resident A's assessment plan states he need assistance with toileting, bathing, and personal hygiene. Resident A was interviewed and stated that "*sometimes*" staff assist him with personal care. Staff Keyosha Hall was interviewed and reported that

	sometimes Resident A's clothing presented as clean, and sometimes not, and that Resident A would wear the same clothing more than one day at a time. Staff Sabra Thomas was interviewed and reported that Resident A's hygiene varied depending on which staff were working. Resident A would be in soiled clothing multiple times at the beginning of first shift at breakfast time. Staff Thomas also confirmed that Resident A would have dirty briefs. Guardian 1 was interviewed and reported that Guardian 1 had to provide personal care to Resident A during his stay at the facility, and that Resident A would be in soiled clothing, and dirty briefs. Guardian 1 stated that it was dirt on Resident A's skin, not his skin rubbing off. Staff Randy Peters was interviewed and reported that there was always a brown substance in Resident A's brief, but claimed it was his "*melanin/skin color*" that would rub off. Staff Peters also reported that Resident A was doing his own toileting, although his assessment plan indicated needed staff assistance. There is a preponderance of evidence to substantiate a rule violation in regard to staff not assisting Resident A with personal care per his assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/01/2023, I spoke with Complainant 1 via phone. Complainant 1 stated yesterday, Resident A had a GI scope done due to him having a big piece of bread lodge in his esophagus. The hospital was able to push it down. Staff Bohn had given Resident A a pretzel because Staff Bohn wanted Resident A to enjoy what everyone else was eating, and disregarded Resident A's physician's orders because he is on a special diet. Resident A had been throwing up for an hour, and 911 was not called until 3:41 pm. Guardian 1 was called at 3:23 pm.

On 09/05/2023, I conducted an unannounced on-site visit at the facility. I interviewed administrator Stacy Bohn. Staff Bohn stated that last Thursday (08/31/2023), she gave Resident A a soft pretzel. Resident A choked on the pretzel. Resident A is on a pureed diet. Staff Bohn stated that she told Guardian 1 that Resident A asked for the pretzel, and that she (Staff Bohn) wanted Resident A to enjoy what the other residents were eating. Staff Bohn stated that Resident A's diet is strictly pureed. Staff Bohn stated that Resident A piled his mouth full of pretzel, while another resident seated next to him was

having a behavior. While the attention was on the other resident, this is when Resident A stuffed his mouth.

On 09/05/2023, I interviewed Resident A at the facility in his bedroom. Resident A stated that he went to the hospital because a pretzel was stuck in his throat. He stated that he can eat any kind of foods and that the day he went to the hospital he choked on a hot dog, honey bun, and pretzel. He stated staff gave him the food.

On 09/05/2023, I obtained requested documentation during the on-site visit. I received a copy of Resident A's Ascension Genesys Hospital *ED Patient Discharge Summary*. The documentation notes that Resident A was evaluated by Dr. E Hammer. It states "*You were evaluated in the emergency room for an esophageal obstruction caused by eating a pretzel which was removed in the emergency room by our gastroenterologist. Please ensure that you do not eat any solid foods and must adhere to a strict pureed diet to prevent choking*."

A copy of Resident A's *Assessment Plan for AFC Residents* dated 03/16/2023 notes that Resident A's special diet is "*1400 ML fluid restriction daily, low sodium, puree, give ensure if consumes less than 50% of meal.*" It also states for *Eating/Feeding* that staff provides Resident A with "*Cues for mealtimes, cues to slow down*." A copy of Resident A's Ascension Living physician order dated for 10/10/2022 notes that Resident A is on a Dysphagia 1 (puree), low sodium diet. The order also states to offer Ensure for meals less than 50% consumed. Resident A's *Health Care Appraisal* dated 03/22/2023 signed by Geralyn Ryan, RN notes "low sodium, Dysphagia 1 (pureed) 1400 mL/24, offer ensure" under *Special Dietary Instructions*.

An *AFC Licensing Division-Incident/Accident Report* dated for 08/31/2023 was obtained. Administrator Stacy Bohn's signature is noted as the person completing the incident report. The only witnesses noted are staff Keyosha Hall, staff Sabra Thomas, and staff Stacy Bohn. The incident report states that at 3:00 pm on 08/31/2023, Resident A was in the dining room "*enjoying a snack of soft pretzels when he began choking*." It further states, "*Staff immediately leaned the resident forward and patted his back, removed the food from his mouth and removed his dentures the resident kept spitting up flem* (phlegm) *and fluid. Staff called PACE and kept trying to assist the resident to cough out the food. Pace told staff to send the resident out to the hospital. Will follow discharge instructions up discharge*."

It should be noted that the details of this incident report, which is signed by administrator Stacy Bohn, is not consistent with the details she provided during her interview on 09/05/2023. There was no mention of any resident(s) causing a distraction in the incident report. It should also be noted that this incident is documented to have occurred at 3:00 pm, yet the time care was given says 3:45 pm. Resident A's discharge summary from the emergency department (ED) notes he was admitted to the ED at 16:22 (4:22 pm). Calls made to PACE and Guardian 1 are documented at 3:17 pm, which reflects calls were made to them prior to 911 for emergency care.

On 09/22/2023, I interviewed staff Keyosha Hall via phone. Staff Hall stated that Resident A is on a pureed diet. Staff Stacy Bohn gave the okay for Resident A to eat a chopped-up pretzel. Resident A was choking, spitting, and drooling until the EMTs arrived about 15 to 20 minutes later. She stated that this is the first incident of it's kind with Resident A that she is aware of. She stated activity coordinator Nina Coleman served Resident A the pretzel.

It should be noted that Staff Coleman was not noted on the incident report, nor was her name and phone number provided when asked for witness information during my on-site on 09/05/2023.

On 10/04/2023, I made a call to the facility. I interviewed staff Sabra Thomas. Staff Thomas confirmed that she worked on 08/31/2023, the day Resident A had the choking incident. She stated that Resident A's pretzel was supposed to have been pureed. She stated that administrator Stacy Bohn told a staff person "*just give it to him, it's fine*." The staff person replied with "*you know he's pureed*," and Staff Bohn reiterated that Resident A would be "*just fine*." Staff Thomas stated that everyone knew, who was present and witnessed this, that Resident A is on a pureed diet. Resident A was coughing/choking for a while, but still talking. Resident A had said he was fine. About five minutes later, staff were patting him on the back, he threw up some, and this is when staff realized he was actually choking. 911 was called. Resident A had been choking for about 30 minutes or more at this point. She stated that this is the first time she's witnessed Staff Bohn giving the okay for this, but she has heard that it is not the first time. The pretzel was a baked one that gets harder as the temperature cools. Resident A ate the whole pretzel. Resident A will eat whatever you put in front of him.

On 10/04/2023, I spoke with Guardian 1 via phone. Guardian 1 stated that administrator Stacy Bohn stated that she felt bad regarding the choking incident and said she (Staff Bohn) takes full responsibility. Guardian 1 stated that not much contact was had with Staff Bohn after this. The apology did not sound genuine, and Staff Bohn wanted staff to lie to Guardian 1 about what happened. Resident A was choking and coughing an hour before the facility called Guardian 1 to notify her of the situation.

On 10/18/2023, I conducted a follow-up phone call with staff Sabra Thomas. She denied that there was any resident sitting next to Resident A that was having a behavior which caused a distraction while Resident A was eating his pretzel. She stated that when Resident A received his pretzel, giving him the pretzel was not a mistake. Staff Nina Coleman, the activity director handed Resident A the pretzel. Staff Thomas stated that she saw Resident A coughing while still eating the pretzel. She stated that she was at the medication room and could see the table Resident A was sitting at. She stated that staff Keyosha Hall had verbally said twice that she thought Resident A was choking. Staff Bohn grabbed a trash can and put it in-between Resident A's legs. The first time Staff Bohn downplayed it, and the second time, Staff Hall started patting Resident A's back. Staff Thomas stated that Staff Bohn said something along the lines of "*I don't understand. He eats cake.*" During this call, I asked

Staff Thomas to confirm from our last conversation that she had reported that Staff Bohn inquired with staff about what they were going to report about this incident. She stated that Staff Bohn did ask what they were going to report if they are asked about the incident, and if they were going to say a pretzel was given to Resident A. Staff Thomas stated that her co-worker (Staff Hall) told Staff Bohn that she was going to report what actually happened, and staff Bohn's reaction to that was as though she didn't like the response.

On 10/23/2023, I conducted a follow-up interview with staff Keyosha Hall. Staff Hall stated that administrator Stacy Bohn did approach her and questioned her on what she was going to report to the family and who she had to report the situation to. She stated that she felt as though Staff Bohn was implying that she wanted Staff Hall to lie about what happened. Staff Hall stated that she wrote and signed an incident report, but the copy of the incident report provided by Staff Bohn during the course of this investigation is not the same incident report Staff Hall wrote out. She stated that there was another resident who did start to have a behavior, but the behavior occurred after Resident A had already been choking and after Staff Hall made the call to PACE to report the choking incident.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	During this investigation, I obtained a copy of Resident A's physician order for his special diet, which consists of a pureed diet, low sodium diet. Resident A's special diet is also noted in his *Assessment Plan for AFC Residents*, and his *Health Care Appraisal*. Complainant 1 reported that staff Stacy Bohn had given Resident A a pretzel because Staff Bohn wanted Resident A to enjoy what everyone else was eating, and disregarded Resident A's physician's orders because he is on a special diet. Resident A was interviewed and confirmed he went to the hospital due to choking on solid food. Staff Sabra Thomas reported that Resident A had been choking for about thirty minutes before 911 was called for Resident A choking, and that Staff Bohn confirmed twice with staff that it was okay to give Resident A a solid pretzel.

	Staff Keyosha Hall also reported that administrator/staff Stacy Bohn gave the okay for Resident A to have the pretzel. There is a preponderance of evidence to substantiate a rule violation in regard to staff not adhering to Resident A's special diet order.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	During this investigation, I obtained a copy of Resident A's physician order for his special diet, which consists of a pureed diet, low sodium diet. Resident A's special diet is also noted in his *Assessment Plan for AFC Residents*, and his *Health Care Appraisal*. Complainant 1 reported that staff Stacy Bohn had given Resident A a pretzel because Staff Bohn wanted Resident A to enjoy what everyone else was eating, and disregarded Resident A's physician's orders because he is on a special diet. Complainant 1 reported that Resident A had been throwing up for an hour, and 911 was not called until 3:41 pm. Guardian 1 was called at 3:23 pm. An incident report for 08/31/2023 was reviewed. The incident is noted to have occurred at 3:00 pm. The incident report notes that Guardian 1 was called at 3:17 pm. PACE was contacted at 3:17 pm, and 3:45 pm is the time noted in the box next to "*Date Care Given*" at Ascension Genesys Hospital. Therefore, the facility documentation shows that 911 was not called prior to making other calls regarding Resident A choking. Resident A was interviewed and confirmed he went to the hospital due to choking on solid food. There is a preponderance of evidence to substantiate a rule violation in regard the facility not responding and seeking care immediately in response to Resident A choking.
CONCLUSION:	**VIOLATION ESTABLISHED**

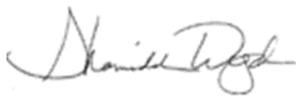
APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	During this investigation, I obtained a copy of Resident A's physician order for his special diet, which consists of a pureed diet, low sodium diet. Resident A's special diet is also noted in his *Assessment Plan for AFC Residents*, and his *Health Care Appraisal*. Complainant 1 reported that staff Stacy Bohn had given Resident A a pretzel because Staff Bohn wanted Resident A to enjoy what everyone else was eating, and disregarded Resident A's physician's orders because he is on a special diet. Resident A was interviewed and confirmed he went to the hospital due to choking on solid food. Staff Sabra Thomas reported that Resident A had been choking for about thirty minutes before 911 was called for Resident A choking, and that Staff Bohn confirmed twice with staff that it was okay to give Resident A a solid pretzel. Staff Keyosha Hall also reported that administrator/staff Stacy Bohn gave the okay for Resident A to have the pretzel. Guardian 1 stated that administrator Stacy Bohn stated that she felt bad regarding the choking incident and said she (Staff Bohn) takes full responsibility. Guardian 1 stated that the apology did not sound genuine, and Staff Bohn wanted staff to lie to Guardian 1 about what happened. There is a preponderance of evidence to substantiate a rule violation in regard suitability of administrator Stacy Bohn

	disregarding Resident A’s pureed special diet order, which led Resident A to have to go to the emergency room due to dysphagia. Also, for failure to act appropriately when Resident A began choking.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/19/2023, and 10/23/2023, I made phone call attempts to contact licensee designee Connie Clauson regarding an exit conference. On 10/24/2023, I sent Connie Clauson an email detailing the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).



10/24/2023

Shamidah Wyden — Date
Licensing Consultant

Approved By:

10/24/2023

Mary E. Holton — Date
Area Manager